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IN THE

Supreme Court of the United States

JANUARY TERM, 1976

NO. 75-1183

PAUL C. EDWARDS,

Petitioner,

v.

THE UNITED STATES OF AMERICA,

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

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Petitioner prays that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Fifth Circuit entered in the appeal of the petitioner on September 17, 1975.

CITATIONS TO OPINIONS BELOW

The opinion of the Court of Appeals is not yet officially reported, and is attached hereto as Appendix

A, with the judgment of that court attached as Appendix B and the Order denying petition for rehearing as Appendix C.

JURISDICTION

The judgment of the Court of Appeals was entered on September 17, 1975. A petition for rehearing was denied on January 20, 1976. The jurisdiction of this Court is invoked under 28 U.S.C., Sec. 1254(1).

QUESTION PRESENTED

Whether a prisoner of the United States, confined in a federal correctional institution, who suffers from serious physical infirmity, is to be afforded medical care and treatment commensurate with a national standard of care, or, as held by the courts below, the standard of care is to be afforded only in accordance with the local standards of the geographical location of the particular correctional institution.

STATUTORY PROVISIONS INVOLVED

18 U.S.C.A., Sec. 4042 provides:

"4042. Duties of Bureau of Prisons

The Bureau of Prisons, under the direction of the Attorney General, shall–

"(1) Have charge of the management and regulation of all Federal penal and correctional institutions,

(2) provide suitable quarters and provide for the safekeeping, care, and subsistence of all persons charged with or convicted of offenses against the United States, or held as witnesses or otherwise,

(3) provide for the protection, instruction, and discipline of all persons charged with or convicted of offenses against the United States,

(4) provide technical assistance to State and local government in the improvement of their correctional systems.

This section shall not apply to military or naval penal or correctional institutions or the persons confined therein."

28 U.S.C., Sec. 1346(b) provides:

"Subject to the provisions of chapter 171 of this title, the district courts, together with the United States District Court for the District of the Canal Zone and the District Court of the Virgin Islands, shall have exclusive jurisdiction of civil actions on claims against the United States, for money damages, accruing on and after January 1, 1945, for injury or death caused by the negligent or wrongful act or omission of any employee of the Government while acting within the scope of his office or employment, under circumstances where the United States, if a private person, would be liable to the claimant in accordance with the law of the place where the act or omission occurred."

28 U.S.C., Sec. 2674 provides; in applicable part:

"The United States shall be liable, respecting the provisions of this title relating to tort claims, in the same manner and to the same extent as a private individual under like circumstances, but shall not be liable for interest prior to judgment or for punitive damages . . ."

STATEMENT

In 1966, petitioner, an oil well wildcatter-promoter seriously ill with high blood pressure, diabetes and heart trouble was convicted of hotly denied counts of securities act violations after hard fought jury trial. Before sentencing medical reports and records were laid before the trial court with request for probation or incarceration in a federal medical center. These pleas were ignored and petitioner was incarcerated in the Federal Correctional Institution at Texarkana, Texas, where his medication was immediately reduced or cut off and the requests of petitioner and his family for proper medical care, or the right to furnish same at the petitioner's expense, also fell on deaf ears. In 1968, while standing in sick call line attempting to get help, petitioner suffered a massive cerebral vascular accident which left him partially paralyzed and totally disabled. Blood specimens taken were referred to as lipid laden to extent of being "creamy". Petitioner's Federal Tort Claims Act claim was denied by the U.S. District Judge for the Eastern District of Texas, who held that petitioner was entitled to only that standard of medical care afforded by a general practitioner of medicine practicing in Texarkana. On appeal the United States Court of Appeals, Fifth Circuit, was divided, two Judges affirming the trial court, but with Chief Judge John R. Brown delivering a strongly worded dissent in favor of petitioner.

The petitioner has been a diabetic since at least 1946. For approximately seven years before his imprisonment, he had been under the care of his personal physician, Dr. Liebendorfer. Treatment was

based primarily on insulin injection and dietary control. His physician had maintained petitioner on from 50 to 80 units daily of insulin and had required a low carbohydrate diet. When petitioner arrived at the federal correctional institution, the Chief Medical Officer immediately reduced the insulin usage to 35 units per day. The institution did not have special diet available, and the medical officer did not require that such be given to petitioner or others similarly situated. Petitioner was required to select foods from the normal prisoner diet. Evidence on the trial indicated the diet furnished was heavily loaded with carbohydrates.

Although suffering from various ailments upon his admission to the institution, petitioner was an active and virile man. After fourteen months confinement, petitioner suffered the massive stroke that left him partially paralyzed on his left side, and rendered him impotent.

Petitioner, in this action, asserted that the negligent failure of the treating physicians at the federal institution to control his diabetes was the proximate cause of his stroke and resulting disability.

The district court found the evidence presented on behalf of the petitioner insufficient as a matter of law to establish either causation or negligence and dismissed the case with prejudice. In so holding, the trial court took the view that the standard of care required of the treating physicians at the federal correctional institution in Texarkana, Texas, was that of a reasonably competent physician in the locality of Texarkana, Texas, and confined the evidence to that standard over the repeated objections of petitioner that such standard was inappropriate to the case inasmuch as the petitioner

was in the custody of the United States, and that the geographical location of the particular institution in question was of no moment in establishing the appropriate standard of care pursuant to the mandate of federal law.

REASONS FOR GRANTING THE WRIT

In recent years, this Court has repeatedly addressed itself to the multi-faceted problems of penal reform and humane treatment of those persons convicted of crimes against the United States. With the law now well settled to the effect that the provisions of the Federal Tort Claims Act apply to federal prisoners,[1] the underlying rule that State law controls the issue of liability under the Act becomes of increasing importance in several situations.[2] The precise extent to which such state law is to be applied is in need of clarification under circumstances such as the case at bar to the end that uniformity of result shall be possible under like circumstances. As interpreted by the courts below in this case, the basic rule that state law controls the issue of liability has been, in the view of petitioner, misconstrued. The law of the State of Texas, according to a majority of the Court of Appeals, will determine in

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[1] *U.S. v. Muniz*, 83 S.Ct. 1850, 374 U.S. 150, 10 L.Ed.2d 805; *Winston v. U.S.*, C.A. N.Y. 1962, 305 F.2d 253, affirmed 83 S.Ct. 1850, 374 U.S. 150, 10 L.Ed.2d 805.

[2] *United States v. Muniz*, 1963, 374 U.S. 150, 163-163, 83 S.Ct. 1850, 10 L.Ed.2d 805; *Richards v. United States*, 1962, 369 U.S. 1, 82 S.Ct. 585, 7 L.Ed.2d 492.

this case whether expert testimony is necessary to establish the negligence of the United States; and, further, will control as to the application of the so-called "locality rule" in medical malpractice cases.

The courts below held that state law controlled in each instance stated; and then further held that, in as much as Texas still retains the rule that only a general practitioner of ordinary prudence and skill, practicing in the Texarkana community or a similar community would serve as the guide for treatment of petitioner, the petitioner could recover only if a breach of that standard of care was made out by the evidence.

The majority opinion of the Court of Appeals contains two fundamental errors in implementation of the rights of petitioner under the Federal Tort Claims Act:

1. The Court of Appeals erroneously applied a purely geographic limitation to the locality rule said to be employed by the Texas courts.
2. The Court of Appeals failed to give proper consideration to the appropriate "community" to be used in applying the locality rule.

Initially, the opinion correctly stated that state law controls the issues of liability under the provisions of the Federal Tort Claims Act. From that base, the court then reasoned that Texas law imposes a duty upon medical practitioners to exercise only that degree of care which a general practitioner of ordinary prudence and skill practicing in the Texarkana, Texas, community or a similar community would have exercised in the

same or similar circumstances.[3] It is most earnestly submitted that the federal statutory requirement that liability issues are controlled by applicable state law does not require or properly allow such a restricted community standard to be applied in this case.

Initially, as pointed out in the dissenting opinion by Chief Judge Brown in this case, it is likely that the majority opinion below misconstrues the Texas law. It is most likely that Texas precedent demonstrates a retreat from the requirement of community or locality standards in measuring the negligence of medical practitioners.[4]

The view that Texas has now abandoned a strict adherence to the locality or community standard rule is supported by numerous decisions of the Texas Appellate Courts. *Giles v. Tyson*, 13 S.W.2d 452 (Tex. Civ. App. 1929); *Christian v. Jeter*, 445 S.W.2d 51

[3]In that regard, the opinion of the Court of Appeals contains the following language: "Applied to this case, Texas law imposes on the treating physician a duty to exercise that degree of care which a general practitioner of ordinary prudence and skill, practicing in the Texarkana community or a similar community would have exercised in the same or similar circumstances."

[4]See Perdue, *The Law of Texas Medical Malpractice*, 11 Houst. L. Rev. 1, 36-38 (1973) It is also significant to note that many jurisdictions have recently abandoned the Locality Rule and have adopted the more realistic rule whereby the standard of care required of a doctor is that of an average practitioner under the same or similar circumstances and the locality in which the practitioner is located is merely one factor to be considered. See, e.g., Brune V. Belinkoff, 1968, 354 Mass. 102, 235 N.E.2d 793; Pederson v. Dumouchel, 1967, 72 Wash.2d 73, 431 P.2d 973. The State of Arkansas, adjacent to the jurisdiction here involved, has abolished the Locality Rule by judicial decision this year. Gambill v. Stroud, Ark. 1976, 529 S.W.2d 330.

(Tex. Civ. App. 1969), *Webb v. Jorns*, 488 S.W.2d 407 (Tex. 1972).

Even if it be assumed, however, that the locality rule is still the law of the State of Texas, the Court of Appeals has misconstrued the rule in its application to the facts of this case. The Texas Courts have long construed the rule as not being a locality rule in the geographic sense, but, rather, a standard of treatment in a medical community similar to that in which the defendant physician practices.[5]

In sum, a proper reading of the current Texas decisions leads to the conclusion that the locality standard to be applied is that of similarity of circumstances, not proximity of location.

The impropriety of imposing the location approach approved in this case to the circumstances of suit by a

[5]In *Hart v. Van Zandt*, Tex. 1965, 399 S.W.2d 791, a neurosurgeon practicing in Pennsylvania was found to be a member of the same school of practice as the defendant, a Texas physician, and was allowed to testify as to the standard of care which the defendant should have exercised in the treatment of a Texas patient. In Perdue, *The Law of Texas Medical Malpractice*, 11 Houst. L. Rev. 1, 36-38 (1973), the author makes the following analysis of current Texas law on the subject: Although this rule may appear liberal and completely accepted, close examination of the holdings in Giles and Christian indicate a trend toward abandonment of any locality restriction. Giles appears to apply a national standard to the care required when using an x-ray. Christian indicates that with the advent of modern transportation and communication, the reason for the rule has now disappeared, and that today there is no lack of opportunity for the physician to keep abreast of current methods and practice. Taking one step further, the Texas Supreme Court in King v. Flamm, holds a general practitioner to the standard of care of a reasonably careful and prudent general practitioner under the same or similar circumstances."

federal prisoner concerning the care received at a federal institution is persuasive. Here the plaintiff is in the custody of the United States, he is confined in a federal institution, treated by a physician who is a salaried employee of the United States. The sole connection this plaintiff and this defendant have with the State of Texas stems from the purely irrelevant fact that the correctional institution happens to be located within the boundaries of that state.

The federal correctional institution involved in this litigation is situated on the southwestern boundaries of the City of Texarkana. The city is one of the few in the nation which encompasses a portion of two states within its corporate limits. The impropriety of the rule followed in this case is readily demonstrable by postulation of a situation under which this federal enclave were to be physically moved less than two miles to the east - which would place it within the boundaries of the State of Arkansas. In *Gambill v. Stroud*, Ark. 1976, 529 S.W.2d 330, the Supreme Court of Arkansas has abandoned, as out-of-date in view of modern communication and travel facilities, the rule that physicians will be held to that standard of skill possessed by doctors in the "same or similar locality." Adopted instead was the test whether the physician, if a general practitioner, has exercised the degree of care and skill of the average qualified practitioner, taking into account the advances in the profession.

Thus, while the petitioner here would remain in federal custody, and incarcerated in premises owned and operated by the United States, staffed with employees of the United States, his right to recover would be sustantially affect by the particular locality in which he was incarcerated. Upon transfer from one

federal correctional institution to another, under the rule approved here, the rights of the prisoners of the United States to care at the hands of the United States would alter and change depending upon the vagaries of state law.

The community standard rule, as it now stands under Texas law, is not a locality rule bounded by the corporate limits of the City of Texarkana, but, rather, a standard of treatment in a community "similar" to that in which the defendant physician practices. In this case, the only community similar to the one in which this physician practiced his profession is another federal facility. The federal correctional institution is not a part of Texarkana, Texas, and the standards of medical competence in that city are in no way shown to be "similar" to the care afforded federal prisoners in other similar federal correctional institutions across the nation.

Whether a national standard is the proper measure of custodial care in a federal enclave or whether the Court determines that Texas has retained a locality rule, the Court of Appeals has approved a construction of the Texas locality rule which is too narrowly drawn. There can be no question but that the rule in Texas reaches at least as far as the community or other "similar communities." In this case, the community in question is the federal enclave, and the only similar communities are other federal enclaves of like nature.

It is most earnestly submitted that this narrow drawing of the duty of the United States to its prisoners violates fundamental concepts of due process of law. The fundamental fairness which undergirds due process dictates that the medical treatment afforded

federal prisoners may not be determined by the luck of the draw as to where their prison term is to be served.

CONCLUSION

For the reasons set forth above, the petition for certiorari should be granted.

Respectfully submitted,

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APPENDIX A

Paul C. EDWARDS,
Plaintiff-Appellant,

v.

UNITED STATES of America,
Defendant-Appellee.

No. 74-2922.

United States Court of Appeals,
Fifth Circuit.

Sept. 17, 1975.

Appeal from the United States District Court for the Eastern District of Texas.

Before BROWN, Chief Judge, and WISDOM and COLEMAN, Circuit Judges.

PER CURIAM:

Paul C. Edwards in this action under the Federal Tort Claims Act, 28 U.S.C. §§ 1346(b), 2671-80 (1970), to recover damages from the United States for injuries allegedly received as a result of negligent medical treatment while an inmate of the Federal Correctional Institute of Texarkana, Texas (F.C.I.). Edwards, then fifty-five, entered prison an active man, though afflicted with diabetes mellitus, angina pectoris, exogenous obesity, and labile hypertension. Fourteen months later, he had a stroke that left him partially paralyzed on his left side. After his release from prison, he filed this suit, alleging that the negligent failure of the treating physicians at F.C.I. to control his diabetes had been a proximate cause of his stroke. The district court, after a full trial, found the evidence insufficient

to establish either causation or negligence and dismissed the case with prejudice. We affirm.

Edwards has been diabetic since at least 1946. For the seven years before his imprisonment, he had been under the care of his personal physician, Dr. Richard Liebendorfer, a board eligible internist. In treating Edwards, Dr. Liebendorfer had relied on insulin and dietary control. Edwards' wife had cooperated closely with Dr. Liebendorfer. She prepared properly balanced diabetic meals and varied insulin dosages to meet demands created by her husband's dietary indiscretions, changes in levels of activity, stress, and other factors affecting his urine sugars. Dr. Liebendorfer had maintained Edwards on 50 to 80 units of insulin per day.

When Edwards arrived at F.C.I. he was taking 50 units of insulin daily. The Chief Medical Officer, after interviewing him, taking his medical history, and evaluating test results, reduced this insulin dosage to 35 units a day, though he later increased it to 40 units.[1] He and his successor maintained the dosage at that level throughout Edwards' imprisonment, except for the period immediately following the stroke when dosages were increased to as much as 80 units daily. Otherwise, there were no variations in the daily dosages. When Edwards first arrived, the Chief Medical Officer discussed with him dietary principles with which, as a

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[1] On November 28, 1967, Dr. Liebendorfer wrote inquiring about the status of Edwards and stating, "I am curious to know whether or not you were able to get him off insulin and maintain normal blood sugars. I have felt the regularity of eating habits if a more strict diabetic control was carried out would be of great benefit to his diabetic status."

long-time diabetic, Edwards was familiar. Edwards' urine sugars were checked four times daily. When high readings resulted, a test for acetone was run. The doctors ordered blood tests at regular intervals during the first eight months of Edwards' imprisonment. During the six months preceding the stroke, however, they ran no blood tests. In January 1969, Edwards had a stroke which, the experts agreed, bore all the earmarks of a thrombosis. Edwards was left partially paralyzed on his left side, impotent, and unable to earn a living in his former occupation as a used-car salesman. He was released from prison in April 1969.

[1-6] State law controls the issue of liability under the Act. *United States v. Muniz*, 1963, 374 U.S. 150, 162-163, 83 S.Ct. 1850, 10 L.Ed.2d 805; *Richards v. United States*, 1962, 369 U.S. 1, 82 S.Ct. 585, 7 L.Ed.2d 492. Texas law, therefore, would determine if expert testimony is necessary to establish the negligence of a physician. *Rewis v. United States*, 5 Cir. 1966, 369 F.2d 595; *Watson v. United States*, 5 Cir. 1965, 346 F.2d 52, *cert. denied*, 382 U.S. 976, 86 S.Ct. 544, 15 L.Ed.2d 467. Applied to this case, Texas law imposes on the treating physicians a duty to exercise that degree of care which a general practitioner of ordinary prudence and skill, practicing in the Texarkana community or a similar community would have exercised in the same or similar circumstances. See, e.g., *Bowles v. Bourdon*, 1949, 148 Tex. 1, 219 S.W.2d 779; *Bender v. Dingwerth*, 5 Cir. 1970, 425 F.2d 378, 384; 45 Tex. Jur. 2d § 131. Texas cases are in agreement that a plaintiff, to recover for injuries suffered from medical negligence, must show, by expert testimony, that the

treating physicians breached the standard of care.[2] *Hart v. Van Zandt*, Tex. 1966, 399 S.W.2d 791; *Bowles v. Bourdon*. The record supports the district court's finding that Edwards failed to bear that burden.

Edwards complains of a number of specific acts and omissions allegedly amounting to negligence: the reduction of his insulin dosage to 40 units daily; the failure to provide him with a diet adequate to his special needs; the refusal to transfer him to a medical facility equipped to handle his problems; and the failure of the young practitioners[3] who treated him to call in a specialist in internal medicine to monitor Edwards' health.[4]

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[2] In *Bowles v. Bourdon*, the Texas Supreme Court said:

> "It is definitely settled with us that a patient has no cause of action against his doctor for malpractice, either in diagnosis or recognized treatment unless he proves by a doctor of the same school of practice as the defendant: (1) that the diagnosis of treatment complained of was such as to constitute negligence and (2) that it was a proximate cause of the patient's injuries."

219 S.W.2d 779.

[3] The first doctor to treat Edwards at F.C.I. was graduated by Columbia University with an A.B. degree in 1961 and by the State Univeristy in New York, Downstate Medical Center College of Medicine, in Brooklyn, New York in 1965. The Public Health Service assigned him to F.C.I. after completion of his internship at the University of Pittsburgh Health Center Hospitals. His successor was graduated with a B.S. degree from the University of Texas in 1962 and the St. Louis Medical School in 1967. He was assigned to F.C.I. after his internship at Methodist Hospital in Houston, Texas. Both are now board certified internists.

[4] Edwards also presses the contention that the failure to take his blood presssure for six months prior to his stroke constituted negligence on the part of the Chief Medical Officer. The record, however, suggests no causal connection between this omission

(continued)

We pass the question of the causal connection between these alleged failures and the stroke. The most salient defect in Edwards' case was the failure to establish by expert testimony that any of these acts amounted to negligence. Dr. Liebendorfer, Edwards' only expert witness, did not express the opinion that Edwards had received improper medical care, nor did he testify as to a standard of care, a predicate on which the court might have based a finding of negligence.

Dr. Liebendorfer testified that many prominent specialists believed that frequent injections of varying doses, correlated to urine sugar levels, was preferable to the single daily dose administered at F.C.I. He offered this, as the district court pointed out, not as a standard of medical care but as a working medical hypothesis. He conceded that there were other medically acceptable approaches. He did not criticize the decision to reduce the insulin Edwards received, nor did he indicate how the level of insulin administered should be determined. He did not indicate that the readings turned up by Edwards' urine tests should have alerted the doctors that his diabetes was not in control.[5] In fact, he did

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(footnote continued from preceding page)

and Edwards' stroke, which the experts agreed had all the appearances of a thrombosis. Tests administered after the stroke revealed no evidence of a hemorrhage. Similarly, there is nothing to suggest that the refusal to permit him to take certain medications prescribed by Dr. Liebendorfer was a cause of the stroke.

[5]Tests run after meals often registered high readings. Early morning tests were always negative or showed only a trace of sugar. A government expert, Dr. Jack C. Smith, testified that higher urine sugar readings after meals were normal and to be expected. Dr. Liebendorfer said nothing to contradict this statement.

(continued)

not indicate why he though the diabetes had not been in control. He did not testify that a diabetic, exercising judgement and restraint, could not obtain a generally adequate diet in the prison cafeteria, although after an examination of typical ten-day menu, he concluded it "might be spotty".[6] He conceded he had no first hand knowledge of the food served there. He also expressed some doubt about the average diabetic inmate's ability to avoid some of the items offered that are proscribed for diabetics. He did testify that he believed Edwards should have seen a consulting specialist in internal medicine once a month. He conceded at the same time that general practitioners regularly treated similar patients without the aid of specialists.

Dr. Jack Smith testified for the United States. Dr. Smith is a diplomate of the American Board of Internal Medicine, and internist in a nineteen-doctor clinic in Texarkana, and a member of the faculty of the Louisiana State Univeristy School of Medicine, Shreveport, Louisiana. He testified that the food served at F.C.I. was comparable to a commercial cafeteria; that

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(footnote continued from preceding page)

Dr. Liebendorfer, in response to questions put to him by the court, did testify that it was recommended that blood sugar tests be run about once every two months in the case of a patient whose diabetes is not easily controlled. He did not indicate a conviction that Edwards' blood should have been checked that often. Indeed, he testified that in Edwards' case, there was a very high correlation between blood sugars and urine sugars. One of the F.C.I. doctors cited this correlation as one of the reasons for taking fewer blood tests.

[6] Examining the whole menu, Dr. Liebendorfer pointed to two meals that he said were inadequate for a diabetic. Dr. Smith, examining the same menu, found one breakfast inadequate because it failed to offer an adequate "fruit exchange".

BLEED THROUGH

the exchange method of diet control was available to appellant nine out of ten days on the ten-day menu sample; that all the elements of a proper diabetic diet were there; that Edwards, following instructions, could have eaten food at F.C.I. consistent with a diabetic diet except on one day when he could not get an adequate fruit exchange. He said that the treatment of Edwards at F.C.I. was consistent with the standard of treatment in the community; that [the] decision to reduce Edwards' insulin from 50 units to 35 units and three months later to 40 units was medically acceptable. Dr. Smith summarized his testimony as follows:

> "On a scale of ideal, fair, satisfactory and unsatisfactory, I would classify Mr. Edwards as fair. His control was fair. He was free of symptoms. His blood sugar was low enough that his 6:00 a.m. sugars were usually trace[d] to negative. His sugars taken after meals usually showed the presence of a large amount of sugar, which is more or less to be expected. . . . There's a physiological reason for trying to keep patients on 35 to 40 units of insulin. The normal human body makes 40 units of insulin a day. This is physiologic. . . . I think [his F.C.I. doctors'] assessment and his medication was proper, so that's about all I have. I think that sums it up."

Dr. Liebendorfer went so far as to say that he believed the F.C.I. physicians had committed a mistake in judgment. This alone is not enough to establish liability. *Hart v. Van Zandt; Bowles v. Bourdon.* Expert testimony must establish a professional standard of care and a deviation from that standard. On this record we need not consider the Edwards' contention that the district court read Texas law too narrowly in holding that the plaintiff had the burden of showing a deviation from the *local* standard of care; that the "community"

involved is the federal penal system and the standards of care to be adhered to must be measured against those of the national community. We find nothing in Dr. Liebendorfer's testimony or in the testimony of the government's experts to establish a deviation from *any* professional standard of care.

The judgment of the district court is affirmed.

JOHN R. BROWN, Chief Judge (dissenting):

While the opinion of this Court cannot cure the grievous physical infirmities of the plaintiff, I regret that we do not take this opportunity to remedy the troika of legal infirmities suffered by the trial court's opinion.

Infirmity No. 1

The Necrosis Of The Locality Rule In Texas

The trial court apparently attempted to resurrect the dying doctrine that a doctor's negligence must be established by the testimony of a doctor familiar with the community of treatment standards of medical practice.[1] I believe that such strict adherence by the

[1] The memorandum opinion of the trial court entered April 22, 1974 provides in pertinent part:

> "Dr. Liebendorfer twice stated that he had never been in Texarkana, Texas; that he had no idea what the medical standards of that community were; and that he knew no docotors [sic] who practived [sic] in Texarkana * * * In addition, the United States called two medical experts who were familiar with medical practices in the Texarkana community. Both stated that there was nothing about Dr. Hotchkiss' treatment of the plaintiff that they considered inadequate by community medical standards.

(continued)

trial court to what has been termed the Locality Rule cannot be squared with developing Texas precedent[2] as well as that of other jurisdictions.[3] Surely modern

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(footnote continued from preceding page)

The court has considered the plaintiff's arguments that the requirement of expert testimony relating to local medical standards is archaic and arbitrary, and that it should not preclude the plaintiff's recovery in a case such as this one, in which the record contains some evidence of mistreatment and neglect. While this court regards the plaintiff's contentions to be forceful and persuasive, nevertheless it cannot justify a departure from the principles of Texas law regarding medical malpractice.
See Appendix at 38-39.

[2]*See generally*, Perdue, *The Law of Texas Medical Malpractice*, 11 Houst.L.Rev. 1, 36-38 (1973).

[3]Several other jurisdictions have abandoned the Locality Rule and adopted a rule whereby the standard of care required of a doctor is that of an average practitioner under the same or similar circumstances and the locality in which the practices is merely a factor to be considered in determining proper care and skill under the circumstances. *See, e.g., Brune v. Belinkoff*, 1968, 354 Mass. 102, 235 N.E.2d 793, 798; *Fernandez v. Baruch*, 1967, 96 N.J.Super. 125, 232 A.2d 661, at 666; *Douglas v. Bussabarger*, 1968, 73 Wash.2d 476, 438 P.2d 829, 837-38. *See also Pederson v. Dumouchel*, 1967, 72 Wash.2d 73, 431 P.2d 973 (held reversible error to limit the standard of care solely to that of the same or similar community); *Hundley v. Martinez*, 1967, 151 W.Va. 977, 158 S.E.2d 159 (Court allowed a New York specialist to testify as to standard of care in a suit tried in West Virginia against a physician with the same special training); *Blair v. Eblen*, Ky., 1970, 461 S.W.2d 370 (where the Court called for the adoption of a national standard of care). *See generally* Waltz, *The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation*, 18 DePaul L.Rev. 408, 418 (1969); Note, *Locality Rule in Malpractice Suits*, 5 Calif.W.L.Rev. 124, 128-31 (1969); Note, *Malpractice and Medical Testimony*, 77 Harv.L.Rev. 333, 338 (1963); Note, *An Evaluation of Changes in the Medical Standard of Care*, 23 Vand.L.Rev. 729, 737-38 (1970).

medical technology, standardized medical education and practice and modern communication facilities dictate the abandonment of a rule which was initially developed to vary the standards of care according to the expertise and training of practitioners in cities as opposed to those in the rural setting.[4]

In Texas it was long ago established that a doctor need not live and work in a community to qualify as an expert witness[5] and in *Hart v. Van Zandt*, Tex., 1965, 399 S.W.2d 791, a neurosurgeon practicing in Pennsylvania was deemed to be a member of the same school of practice as a Texas physician and accordingly was allowed to testify as to the standard of care which the latter should have exercised in the treatment of a patient in Texas.

Particularly with a disease such as diabetes where doctors uniformly agree, as they did in the trial court,[6] that the treatment is a combination of insulin injections and dietary control a doctor experienced in the treatment of this disease would be qualified to testify as to the standard of care to be exercised by physicians treating the disease and in the Eyes of Texas the locality of the witnesses' own practice or localizing the standard to the community of treatment would not be decisive.

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[4] *See* Perdue, *The Law of Texas Medical Malpractice, supra* at 36.

[5] *Turner v. Stoker*, Tex.Civ.App., 1926, writ ref'd, 289 S.W. 190, 194.

[6] The District Court recognized in its memorandum opinion that all the doctors who testified believed that dietary control was an integral part of the treatment of diabetes. *See* App. at 34.

Infirmity No. 2
The Burden Of Proof Is Overweight

Another pointed inadequacy of the trial court's opinion[7] and that of the majority of this Court[8] is that the plaintiff was required to show by expert testimony that the prison doctors were *negligent*.

Substantial Texas authority[9] supports the proposition that what constitutes negligence is a mixed question of law and fact and the resolution of this ultimate issue is within the exclusive province of the trier of fact.

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[7]The trial court states in its memorandum opinion that:

> It is further required that the opinion evidence offered by the plaintiff be to the effect that the physician whose conduct is the subject of inquiry was negligent according to the standards of the community in which he was practicing. *Cleveland v. Edwards*, 494 S.W.2d 578 (Tex.Civ.App.—Houston [14th Dist.] 1973).
> *See* App. at 37.

The Court further aborated its belief that the expert witness must state that the doctor's conduct was negligent by saying:

> Although Dr. Liebendorfer testified that he would have procured the services of a dietician had he been the medical authority at FCI, *he did not give the opinion that the failure to do so was negligent or inadequate according to medical standards.* (Emphasis added).
> *Id.*

[8]This Court states unequivocally:

> The most salient defect in Edwards' case was the failure to establish by expert testimony that any of these acts amounted to negligence.

P. 7843.

[9]The leading case is *Snow v. Bond*, Tex., 1969, 438 S.W.2d 549, 550-51 which states in pertinent part:

(continued)

Accordingly, it is quite improper to require the plaintiff to bear the extraordinary burden of bringing forward expert testimony stated in conclusory terms of negligence or its equivalent to establish negligence (or proximate cause).[10]

This basic error then leads the Court to conclude that there is no evidence of "negligence".[11] Of course

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(footnote continued from preceding page)

> "What constitutes negligence or malpractice is a mixed question of law and fact that can only be determined by the trier of fact on the basis of evidence admitted and instructions given by the court. A medical expert is not competent to express and opinion thereon. See *Houston & T.C.R. Co. v. Roberts*, 101 Tex. 418, 108 S.W. 808. The question of what a reasonable and prudent doctor would have done under the same or similar circumstances must also be determined by the trier of fact after being advised concerning the medical standards of practice and treatment in the particular case. An expert witness can and should give information about these standards without summarizing, qualifying or embellishing his evidence with expressions of opinion as to the conduct that might be expected of a hypothetical doctor similarly situated. The latter is not an appropriate subject for expert testimony. See *Phoenix Assur. Co. of London v. Stobaugh*, 127 Tex. 308, 94 S.W.2d 428."

See also Sanchez v. Wade, Tex.Civ.App.–El Paso, no writ, 1974, 514 S.W.2d 812, 815; *Prestegord v. Glenn*, Tex. Civ.App.–Amarillo, 1970, 451 S.W.2d 791, *reversed on other grounds*, Tex., 456 S.W.2d 901; *cf. Bender v. Dingwerth*, 5 Cir., 1970, 425 F.2d 378, 385.

[10]The Texas Supreme Court had held that while expert testimony as to the "possibility" of medical negligence or causation is not determinative of negligence, it is admissible and probative of the issue. *Bowles v. Bourdon*, 1949, 148 Tex. 1, 219 S.W.2d 779; *see also* Musselwhite, *Medical Causation Testimony in Texas: Possibility v. Probability*, 23 Sw.L.J. 622, 624.

[11]P. 7845.

while it is true that the plaintiff's expert never in so many words testified that the prison doctor's conduct was negligent or violated a standard of care, but in the Eyes of Texas the weight to be given medical testimony should be determined by the substance of the testimony of the expert witness and does not turn on semantics or on the use by the witness of any particular conclusory term or phrase.[12] Upon a close examination of the substance of Dr. Liebendorfer's[13] testimony, it is evident that the prison doctors were to some degree negligent[14] and that their negligence was a contributing

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[12]*Insurance Company of North America v. Myers*, Tex., 1966, 411 S.W.2d 710.

[13]Dr. Liebendorfer not only fills the shoes of an expert witness, but also has additional knowledge of the plaintiff's individual physical problems because he successfully treated him for a number of years before he was incarcerated.

[14]The plaintiff's expert witness, Dr. Liebendorfer, made several statements which indicated that the prison doctors negligently treated plaintiff's diabetic condition. *See, e.g.*, R.Vol. III at 74 (that the combination of diet, insulin injections and the administering of other drugs to control the other maladies of the plaintiff had resulted in successful treatment prior to his incarceration); R.Vol. III at 91 (prison officials should have provided a special diet for inmates with need for dietary control); R.Vol. III at 99 (the prison doctors should have checked plaintiff's blood pressure more often); R.Vol. III at 86, 126 (prison doctors should have kept plaintiff on a controlled regimen of insulin dosages and dietary control and the failure to do so in the witnesses estimation was a contributing factor to the plaintiff's stroke).

cause[15] of the plaintiff's stroke.

Thus, the majority's broad statement that the plaintiff failed to establish a deviation from *any* professional standard of care[16] is both overstatement and approval of a fact-legal conclusion under the overpowering influence of an incorrect legal standard. It provides an inadequate basis for the majority's out of hand rejection of the plaintiff's case.

Infirmity No. 3
This Is Not Malpractice But A Gaoler's Case

Probably the most fundamental malady suffered by the trial court's opinion is that it treated this case as if it were a malpractice suit rather than judging the propriety of the plaintiff's claim in light of the duty imposed by statute upon the Bureau of Prisons under the direction of the Attorney General of the United States to exercise ordinary care[17] to provide for the

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[15]There is also ample expert medical testimony of causation. *See, e.g.*, R.Vol. III at 68-69 (causal connection between diabetes and circulatory ailments and more particularly stroke); R.Vol. III at 86 (failure to control plaintiff's insulin dosages and diet was a contributing cause of the stroke); R.Vol. III at 126 (expert states that if plaintiff had been kept on the controlled regimen, as to diet and drug dosages, which he lived under prior to his incarceration he probably would not have had his stroke).

[16]P. 7845.

[17]*Bourgeois v. United States*, N.D.Tex., 1974, 375 F.Supp. 133; *Brown v. United States*, E.D. Ark., 1972, 342 F.Supp. 987; *Cohen v. United States*, N.D.Ga., 252 F.Supp. 679, *reversed on other grounds*, 5 Cir., 389 F.2d 689.

health and welfare of federal prisoners.[18]

In the case at hand the parties stipulated that the government had notice of the plaintiff's physical infirmities[19] before he was incarcerated. Nevertheless, the prison officials following routine practice confiscated from the plaintiff upon his arrival at the prison all of the medications which he took to aid him in coping with his various physical problems except for his nitroglycerin.[20] The doctors in this case agree that

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[18]18 U.S.C.A. § 4042 requires:

§ *4042. Duties of Bureau of Prisons*

The Bureau of Prisons, under the direction of the Attorney General, shall–

(1) have charge of the management and regulation of all Federal penal and correctional institutions;

(2) provide suitable quarters and provide for the safekeeping, care, and subsistence of all persons charged with or convicted of offenses against the United States, or held as witnesses or otherwise;

(3) provide for the protection, instruction, and discipline of all persons charged with or convicted of offenses against the United States;

(4) provide technical assistance to State and local government in the improvement of their correctional systems.

This section shall not apply to military or naval penal or correctional institutions or the persons confined therein.

[19]*See* R.Vol. I at 65. *See also* letters set out in the appendix at 417-24.

[20]*See* R.Vol. I at 66. At the time of his incarceration the plaintiff was taking marplan, a drug which was used in conjunction with nitroglycerin to treat his heart condition. R.Vol. III at 74. In addition, he was taking a drug called Rauwiloid for his high blood pressure as well as Librium and Phenobarbital which were relaxants. *Id.* Dr. Liebendorfer testified that these drugs were necessary for the continued maintenance of plaintiff's health. *See* R.Vol. III at 100-01.

proper treatment of diabetes includes both dietary control and insulin injections. Yet, the testimony of Dr. Liebendorfer and Dr. Cyprus indicates that the prison diet was inadequate for a diabetic's needs[21] and Dr. Hotchkiss stated that the plaintiff had a hard time adhering to a proper dietary regimen.[22] Nevertheless, prison doctors refused to recommend the establishment of a special cafeteria line for diabetics.[23] While I recognize that proper dietary control may allow a physician to reduce insulin dosages, it seems inappropriate for Dr. Hotchkiss to reduce the plaintiff's dosage from 50 units to 35 units per day[24] in view of the prison's recalcitrance in providing dietary control.

We would not hesitate to impose liability upon the government if a prisoner sustained injury because he was required to live in conditions not fit for human habitation and in the same way we should not allow the federal prison system to force a prisoner to live under conditions which are repugnant to his individual physical needs. Similarly, it has been held in this Circuit[25] that state prisons have the duty to provide

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[21]For medical testimony to the effect that the prison diet was inadequate for a diabetic, see R.Vol. III at 86, 91, 99, 126, 301.

[22]R.Vol. II at 96.

[23]R.Vol. II at 98.

[24]R.Vol. II at 29-30.

[25]*See, e.g., Newman v. Alabama,* 5 Cir., 1974, 503 F.2d 1320 (pending en banc on Eleventh Amendment issue) (class action by inmates in state prison challenging the uniform practices of neglectful medical treatment by prison officials); *Gates v. Collier,* 5 Cir., 1974, 501 F.2d 1291 (pending en banc on Eleventh Amendment issue) (conditions which deprived inmates of basic elements of hygiene and adequate medical treatment held constitutionally impermissible).

adequate medical care and failure to do so gives rise to a cause of action with due process underpinnings under 42 U.S.C.A. § 1983. I believe that the liability of federal prisons should be judged by the same standards under the Federal Tort Claims Act.[26]

In *Logue v. United States*, 1973, 412 U.S. 521, 532-33, 93 S.Ct. 2215, 2222, 37 L.Ed.2d 121, 131, the Supreme Court clearly recognized that liability under the Federal Tort Claims Act could arise if a federal official knew or should have known of a prisoner's infirmity and yet failed to take action to prevent injury to the prisoner. Upon the same rationale, the prison officials could be held to have violated their duty of safe keeping by failing to adequately attend to the plaintiff's medical needs after having been apprised of his various physical infirmities.

One could argue that liability under the Tort Claims Act is improper in the prison setting because the Act is designed to impose liability on the government as if it were a private individual and individuals do not operate prisons. But to those doubting souls I must once against stress, as I did in my dissenting opinion in *Logue v. United States*, 5 Cir., 1972, 463 F.2d 1340, 1341-42, *vacated and remanded*, 1973, 412 U.S. 521, 93 S.Ct. 2215, 37 L.Ed.2d 121 (on petition for rehearing en banc), that "[o]nce the Government undertakes performance of an act entailing a duty of ordinary care it may not thereafter avoid liability under the Federal Tort Claims Act simply by abandoning the undertaking and attempting to attribute the responsibility to someone else." *Indian Towing Company v. United States*, 1955, 350 U.S. 61, 69, 76 S.Ct. 122, 126, 100

[26]Particularly, 18 U.S.C.A. § 4042.

L.Ed. 48, 56; *United States v. Gavagan*, 5 Cir., 1960, 280 F.2d 319, *cert. denied*, 1961, 364 U.S. 933, 81 S.Ct. 379, 5 L.Ed.2d 365.

Another reason why it is absurd to measure the duty of the Federal Government to provide medical care to prisoners by standards of medical malpractice is that the degree of care which the government must exercise varies according to the locality of the prison. Indeed, a uniform standard would be more appropriate for prison physicians whose only nexus with the medical standards of the locality is that the prison to which they are assigned happens to be geographically situated there.

For any one or all of these three reasons the action of the trial court ought not to be accepted and this Court ought to declare these principals and remand the case for a consideration of the facts in light of the correct legal standards rather than artificially characterizing this case as a malpractice suit between a private citizen and a freely selected physician.

APPENDIX B

UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

October Term, 1974

No. 74-2922

D.C. Docket No. CA 1943

PAUL C. EDWARDS,

Plaintiff-Appellant,

versus

UNITED STATES OF AMERICA,

Defendant-Appellee.

Appeal from the United States District Court for the Eastern District of Texas

Before BROWN, Chief Judge, and WISDOM and COLEMAN, Circuit Judges.

JUDGMENT

This cause came on to be heard on the transcript of the record from the United States District Court for the Eastern District of Texas, and was argued by counsel;

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this Court that the judgment of the said District Court in this cause be, and the same is hereby, affirmed;

It is further ordered that plaintiff-appellant pay to defendant-appellee, the costs on appeal to be taxed by the Clerk of this Court.

September 17, 1975

JOHN R. BROWN, Chief Judge, dissenting.

Issued as Mandate:

APPENDIX C

IN THE UNITED STATES COURT
OF APPEALS
FOR THE FIFTH CIRCUIT

No. 74-2922

PAUL C. EDWARDS,

versus

UNITED STATES OF AMERICA,

Appeal from the United States District
Court for the Eastern District of Texas

ON PETITION FOR REHEARING
(JANUARY 20, 1976)

Before BROWN, Chief Judge, WISDOM and COLEMAN, Circuit Judges.

PER CURIAM:

IT IS ORDERED that the petition for rehearing filed in the above entitled and numbered cause be and the same is hereby denied.

In the Supreme Court of the United States

OCTOBER TERM, 1975

No. 75-1183

PAUL C. EDWARDS, PETITIONER

v.

UNITED STATES OF AMERICA

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. A) is reported at 519 F. 2d 1137. The opinion of the district court is not reported.

JURISDICTION

The judgment of the court of appeals (Pet. App. B) was entered on September 17, 1975, and the petition for rehearing (Pet. App. C) was denied on January 20, 1976. The petition for a writ of certiorari was filed on February 19, 1976. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

QUESTION PRESENTED

Whether the court of appeals correctly affirmed the district court's finding that government physicians had not been negligent in treating petitioner.

STATEMENT

While in his fourteenth month of confinement in the Federal Correctional Institution at Texarkana, Texas, petitioner suffered a stroke which left him partially paralyzed on the left side (Pet. App. 1a). For several years prior to his incarceration, petitioner had suffered from diabetes mellitus, which was treated by periodic insulin injections and dietary control. After his release from prison, petitioner instituted this action against the United States under the Federal Tort Claims Act, 28 U.S.C. 1346(b), 2671 *et seq.* The complaint alleged that the negligent failure of the prison doctors to treat his diabetes in a proper manner had been the proximate cause of his stroke (C.A. App. 3-7).[1]

Following a bench trial in the United States District Court for the Eastern District of Texas, the case was dismissed with prejudice. The court found that the evidence was insufficient to establish either that the government physicians had been negligent in caring for petitioner's illness[2] or that their treatment had been the proximate cause of his stroke (C.A. App. 39-40).

The court of appeals affirmed (Pet. App. 1a-8a), one judge dissenting (Pet. App. 8a-18a). The court found that it need not reach the question whether the district court had erred in finding no causal connection between the alleged acts of negligence and petitioner's stroke (Pet. App. 3a). Nor did it find it necessary to consider

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[1]"C.A. App." refers to the appendix in the court of appeals.

[2]Concerning petitioner's two primary allegations of negligence, the court specifically found (C.A. App. 39):

> [N]ot a single medical witness was willing to say that the reduction of insulin dosage constituted a breach of professional standards. Further, there was no evidence whatsoever on which the court could reach the conclusion that failure to afford diabetics a separate diet in the cafeteria is patently negligent.

petitioner's argument that the district court applied an overly narrow geographic standard in determining the appropriate standard of care against which to measure the performance of the government physicians under Texas law (Pet. App. 3a, 7a). Instead, the court held that (Pet. App. 7a-8a; emphasis in original):

> On this record * * * [w]e find nothing in [the testimony of petitioner's expert] or in the testimony of the government's experts to establish a deviation from *any* professional standard of care.

ARGUMENT

In this Court, petitioner renews his contention (Pet. 8-9) that the district court misapplied Texas tort law by adopting a local, geographic definition of the community to be considered in deriving the appropriate standard of care. He also contends (Pet. 11) that the appropriate standard of medical care for federal prisoners should be defined on a nationwide basis. But in this case, it is irrelevant whether the proper standard is that of the local community or of the nation generally. As the court of appeals correctly determined, the treatment provided petitioner by the government physicians was not negligent under "*any* professional standard of care." Since petitioner has not attempted to show that this conclusion was erroneous, further review of this issue is foreclosed. Cf. *Graver Mfg. Co.* v. *Linde Co.*, 336 U.S. 271, 275.

In any event, the district court was correct in applying a local standard. It is well settled that in suits brought under the Federal Tort Claims Act, federal courts must apply the law of the place where the act or omission occurred, including its definition of negligence, in determining the liability of the United States. 28 U.S.C. 1346(b); *United States* v. *Muniz*, 374 U.S. 150; *Richards* v. *United States*,

369 U.S. 1. In *United States* v. *Muniz, supra,* 374 U.S. at 161-162, this Court specifically stated that in suits by federal prisoners for injuries suffered because of the negligence of government employees, the law of the situs controls. Indeed, the Court noted that "[e]ven a matter such as improper medical treatment can be judged under the varying state laws of malpractice * * *." *Id.* at 162. The district court here correctly followed *Muniz.*

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

ROBERT H. BORK,
Solicitor General.

APRIL 1976.